# Foreword

Two approaches—chronological and geopolitical—governed much of what is included in *Massachusetts Health Care Trends: 1990-2001*. We looked at our health care system in the broadest possible way and asked two basic questions: How has the system changed since 1990 and in what ways does it differ from the United States as whole?

"A Decade in Review" (see page 1), is an analysis of actual events whose meaning and significance in the larger picture is open to interpretation. We offer an interpretation that rings true to us from our vantage point, knowing that others will have different interpretations of the same events.

The body of the report is a chart book, an extensive set of graphs with explanatory bullets, some of which draw the reader's attention to related information in another section.

"Chapter 3: Health Care Delivery System" (see pages 33-62) includes information concerning the financial margins of hospitals, nursing homes and community health centers, but in the text we refer to the related financial margins of HMOs found in "Chapter 2: Health Care Financing" (see pages 19-32). Such distinctions between providers and financiers are somewhat arbitrary given the role-blurring that occurred over the last ten years (see page 2), but the reader is directed to related graphs when relevant.

The appendices include a reference list of hospital and HMO consolidations, and a timeline which provides a helpful chronological listing of events. As time passes and changes are institutionalized, it's often difficult to remember, for example, when the HEDIS data set measuring health plan performance was established (see page 82) or when Harvard Community Health Plan and Pilgrim Health Care became Harvard Pilgrim Health Care (see page 84).

Some who will read this report are primarily concerned with the health of the system, others with the health of institutions, and still others with the health of individuals. We hope that *Massachusetts Health Care Trends: 1990-2001* serves all equally well and that you will revisit it again and again.

# A Word About the Division

The Division of Health Care Finance and Policy (DHCFP) collects, analyzes, and disseminates information with the goal of improving the quality, efficiency, and effectiveness of the health care delivery system in Massachusetts. In addition, the Division administers the Uncompensated Care Pool (UCP), a fund that reimburses Massachusetts acute care hospitals and community health centers for services provided to uninsured and underinsured people.

### Satisfying the Need for Health Care Information

The effectiveness of the health care system depends in part upon the availability of information. In order for this system to function properly, purchasers must have accurate and useful information about quality, pricing, supply, and available alternatives. Providers need information on the productivity and efficiency of their business operations to develop strategies to improve the effectiveness of the services they deliver. State policy makers need to be advised of the present health care environment as they consider where policy investigation or action may be appropriate.

As part of its health care information program, the Division publishes reports that focus on various health care policy and market issues.

## Mission

The Mission of the Division is to improve the delivery and financing of health care by providing information, developing policies, and promoting efficiencies that benefit the people of Massachusetts.

Our goals are to:

- assure the availability of relevant health care delivery system data to meet the needs of health care purchasers, providers, consumers, and policy-makers
- advise and inform decision makers in the development of effective health care policies
- develop health care pricing strategies that support the cost-effective procurement of high quality services for public beneficiaries
- improve access to health care for low-income uninsured and underinsured residents.

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**Massachusetts Health Care Trends: 1990-2001**

# A Decade in Review

*This "Decade in Review" is original to Massachusetts Health Care Trends: 1990-1999.*

By almost any measure, the last ten years have been tectonic ones for health care in Massachusetts, leaving no industry sector untouched. Most observers would say these changes have left our health care institutions worse off than in 1990. Objective indicators, primarily financial, largely confirm that impression.

Exactly where were we in 1990? Were those really the good old days of health care? What were the seminal events that brought us to where we are in 2000? In what ways are we and our health care industry better off than in 1990?

## Indicators and Paradigm Shifts

This report summarizes the past decade and shows how the current health care situation developed. We have selected important trends to tell the story. Most indicators show tremendous change but, remarkably, some look no different than in 1990. Many lend weight to the often-heard mantra, "Massachusetts is different" from the United States as a whole. Some simply reflect trends that occurred in our society, such as a widening of the income disparity between the highest- and lowest-earning families.

Many of the highlighted indicators interrelate in a loose cause and effect relationship that is rarely easy to see without the benefit of hindsight. The largest changes—paradigm shifts—cannot be adequately depicted in a graph or chart. Six such shifts best summarize the decade.

## The States Tackle Health Care Reform

The first paradigm concerns the turn in attention from the federal to the state level for health care reform. In 1993, a new president set out to remake the health care system to address both rising health care costs and the rising number of uninsured. When efforts for reform collapsed at the federal level, action on these issues devolved to the states to a greater extent than in any previous time.

Many states passed legislation suited to their own demographics and political forces. In Massachusetts for example, one of the success stories of the decade is the substantial progress in decreasing the number of uninsured through Medicaid expansion, small group and individual insurance reform, and the Children's Health Insurance Program (a federally driven expansion but one inspired nationally by a Massachusetts reform, Chapter 203 of 1996). Today, states have assumed the reform role once associated with Congress and many people look to the states for leadership and incubation of ideas in health care.

## HMOs Pushed the Market—and the Market Pushed Back

The second paradigm concerns Massachusetts HMOs that morphed from tightly

controlled exclusive networks to equal opportunity contractors, while their reputation in the general media faded from savior to villain. In 1990, there were high expectations that HMOs would not only retard the growth in health care spending but also correct many of the glaring faults of indemnity insurance.

Lost in today's incessant HMO bashing is the memory of paying out of pocket for well child care and adult preventive services, the patient's endless paperwork required for reimbursement, the systemic incentives for over-treatment, and the lack of payer oversight regarding the quality of services provided. Managed care has addressed, albeit imperfectly, these faults and others. It has also enabled the development of the fledgling science of outcomes measurement by virtue of its large databases and acknowledged role in "managing" care.

Indemnity insurers have a stake in ferreting out fraud and abuse but less standing and stake in measuring and improving care—an effort we now take for granted, but which was barely a whisper in 1990. It is no coincidence that the Institute for Health Care Improvement, incorporated in 1991, is based in Massachusetts, nor that its founder, Dr. Donald Berwick, was one of the early officers of Harvard Community Health Plan. The introduction of HMOs is inexorably linked to the spread of the outcomes measurement/quality improvement movement and is one of the triumphs of the 1990s.

But Massachusetts HMOs started the decade as insurers with restricted panels of contracted providers and ended the decade with nearly identical universal panels of providers. Their early promise to hospitals that, in exchange for deep discounts, the hospital would be one of only a handful to receive all of an HMO's admissions evaporated, as the plans capitulated to market pressure in an effort to buy market share. Consumers and their employers insisted on a dilution of the HMO network model to retain their historical choice to receive care anywhere—but at HMO level premiums.

In 1994, pharmacies across the state succeeded in passing "any willing provider" legislation which stipulated that HMOs had to contract with any pharmacy willing to meet their prices, and in 1997 Harvard Pilgrim Health Care lost a battle to New England Medical Center to maintain the right to exclude unneeded hospitals from its network. These two events signaled the end of selective contracting with deep discounts for volume, and the beginning of deep discounts for … nothing.

## Health Care Players Acquire New Roles

The third paradigm shift of the decade is one of role blurring. No sector in 2000 is purely what it was at the onset of the decade. Provider, insurer, payer, purchaser, patient—we used to know what these were and could name an example of each.

Doctors and hospitals provided medical care but weren't at risk for its cost. That was the insurers' role before they also become known as providers who employed salaried doctors or owned hospitals and health centers. Employers were the insurers' clients on the commercial side until they took shelter in self-insurance—and their former insurers became simply their agent-payers.

Patients were, well, patients, until they became partners in their own health care, not to mention Internet investigators, medical error vigilantes, and pharmaceutical advertising targets. Medicaid used to be a payer until it saw its future in managed care and became a purchaser. And Medicare is juggling both payer and purchaser roles in an effort to hedge its bets, conserve its trust fund, and keep the political wrath of the elderly at bay.

## A New Cosmology

The fourth paradigm concerns the role of hospitals as the centerpiece of our system.

Managed care, enabled by the twin forces of technology and pharmaceuticals, transformed the process of medicine and as a by-product, its principal site of care. Along the way, we learned that the Copernican model of health care with all entities revolving around the hospital, was no longer always necessary and, sometimes, not even preferable. Hospitals began to share the spotlight—and dollars—with many other sites. Handoffs of care, which used to refer to transferring patient information during a nursing change of shift, now commonly refers to transfers between types of providers—different institutions often with separate ownership speaking a different internal language and often operating under a different reimbursement incentive.

Hospitalizations and hospital days both decreased steadily from 1990 through 1996 (days continued decreasing through 1999) despite the aging of the population. Shorter lengths of inpatient stay, made possible by technology and pharmaceuticals, created a bulge in home health care (see Figure 3.9 on page 44) and prescription drug use (see Figure 3.10 on page 45). Today's fragmented care picture is a part of our landscape and presents challenges for professionals as well as patients.

## To Regulate or Not to Regulate?

The fifth paradigm concerns the role of and regard for government involvement in health care in Massachusetts. The decade saw a shift away from strict rate setting to, lately, a call for a return to greater government involvement, particularly in HMOs. In 1990 Massachusetts was one of a handful of states with broad rate setting done centrally for its health care services but in 1991 a new Governor fought to "take the regulatory wraps off health care" and on September 30, 1991 the hospital rate setting authority expired, replaced in December, 1991 with Chapter 495.

Now, patient advocates as well as many industry experts are calling for a return to more involvement in health care by state government. This is widely seen as a backlash to the receivership of Harvard Pilgrim Health Care and the dismal fiscal condition of many Massachusetts hospitals, nursing homes and community health centers (See Figures 3.22, 3.23 and 3.24 on pages 57-59).

Oversight is more favorably regarded not only in financial matters but also in provider closings, sales of institutions to for-profit companies, scope of and access to services offered, and medical errors. Market forces, which were viewed as an aid in keeping costs down when most interested parties lobbied for a relaxing of regulation ten years ago, have proven to be unforgiving and overly destructive, especially when coupled with the force of the federal Balanced Budget Act of 1997.

## Patients Become Clients

Finally, in ten years, an industry that used to be described as a service is now a business, its patients, now clients. In particular, many women who are the most frequent users of health care and by far the most frequent providers of familial care-giving, became disillusioned with the status quo even before the opening of the decade. Their dissatisfaction added voice to historically disenfranchised but less powerful groups such as the uninsured, linguistic and ethnic minorities and other marginalized populations such as homosexuals. Numerous and well-publicized examples of how ill-served these groups were sparked an effort to gain power in such areas as childbirth and AIDS care.

Strengthened by the sheer bulk of baby boomers experiencing the system en masse for themselves and their parents, these aroused consumers catalyzed a redefinition of the long-standing paternalistic patient-physician relationship. Horrified in 1995 by

the most widely publicized medical error in recent memory and astonished by where it occurred and to whom,* all consumers learned that health care is not immune to the errors of other industries, but the stakes are often higher.

Adding fuel to an already vital consumer movement, the Internet transformed information gathering and sharing in health care. It is estimated that as many as one in three patients who visits his or her doctor now brings information gathered from a health care Internet site. While still in its infancy, the Internet's potential for revolutionizing our health care system is obvious even as the exact dimensions of how that will happen are vague. As a tool with genuine promise to return significant cost savings, particularly in the area of administrative processes, it has already had the paradoxical effect of putting so much information in the hands of consumers that the pressure on providers to prescribe the latest drug or experimental treatment may in fact drive up medical costs in the short term.

While patients have become consumers, however, we have not accepted the central reality of most other consumer transactions—value costs money. We want indemnity-like choice, alternative medicine, the latest technology and cutting edge pharmaceuticals, futile or unproven treatments, conveniently located MRIs—all for a $5 copayment. Largely insulated from the price of these desires, we approach the next decade with our health care industry in jeopardy.

* Betsy Lehman, health writer for *The Boston Globe*, died and Maureen Bateman was seriously injured from a chemotherapy overdose at Dana-Farber Cancer Institute in 1994.